

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Snow Hill</b> c. LENGTH OF STAY IN lb <b>23 1/2</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>416 Covington St.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Snow Hill</b> d. STREET ADDRESS <b>Dighton Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Jerome E. Bratten</b>		4. DATE OF DEATH Month Day Year <b>Sept. 20 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 8, 1910</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <b>56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never Worked</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Snow Hill, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James E. Bratten</b>		14. MOTHER'S MAIDEN NAME <b>Levater Collick</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, at unknown) (If yes give war or dates of service) <b>No -----</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Rossie W. Bratten, Salisbury, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Probably Essential</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>David R. R. DAVID R. R.</b>		22. DATE SIGNED <b>9-21-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/21/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Wesley Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Snow Hill, Md.</b>	
24. FUNERAL DIRECTOR <b>Gualdo C. Sound</b>		25. REC'D BY REGISTRAR <b>SEP 26 1966</b>	
ADDRESS <b>Snow Hill, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

10481

10481

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

13457

Item #2d Film #G387 10/1/66 pc

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13452

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b> c. LENGTH OF STAY IN 1b <b>23-1</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>		d. STREET ADDRESS <b>206 West Street</b> <b>MVANN/11/17</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDNA BURBAGE BRITTINGHAM</b>		4. DATE OF DEATH <b>SEPT. 27 1966</b>		5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG 31, 1885</b>		9. AGE (In years last birthday) <b>81 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BERLIN MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES I. BURBAGE</b>		14. MOTHER'S MAIDEN NAME <b>MARY KATHARINE DAVIS</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>MRS. KATHARINE YERMAN</b>		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary edema</b> <b>4200</b> DUE TO (b) <b>Congestive heart failure</b> DUE TO (c) <b>Atherosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>6 mon</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 19 <b>61</b> , to <b>9/27</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>9/26</b> 19 <b>66</b> , and that death occurred at <b>9/27</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Frank E. Bantz Jr.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/29/66</b>		22c. PHYSICIAN'S NAME (Type) <b>FRANK E. Bantz Jr.</b>	
22d. ADDRESS <b>Bay St. Berlin Md</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/29/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>	
23d. LOCATION (City or Town) (County) (State) <b>BERLIN WOR. MD</b>		24. FUNERAL DIRECTOR <b>Anna A. Burbage Berlin Md</b>		25a. REC'D BY REGISTRAR <b>SEP 30 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	

1945

1945



FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13458

13453

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berlin</b> c. LENGTH OF STAY IN 1b <b>6 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>107 West Street</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Id.</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berlin</b> d. STREET ADDRESS <b>107 West Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Augustine Durkin Burroughs</b>				4. DATE OF DEATH Month Day Year <b>Sept. 19 1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-2-1928</b>	
9. AGE (In years last birthday) <b>38</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William Gurkin</b>				14. MOTHER'S MAIDEN NAME <b>Annabelle Lee</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>246-30-9047</b>		17. INFORMANT <b>William T. Burroughs</b> Address <b>Berlin, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b> <b>330x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Clifford E. Schott</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Clifford E. Schott, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Acting <b>9-20-66</b>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-20-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen</b>		23d. LOCATION (City, town or county) (State) <b>Worcester Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Anna A. Burbage</b> ADDRESS <b>Berlin, Maryland</b>				25a. REC'D BY REGISTRAR <b>SEP 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

13453

13453



# FOR STATE HEALTH DEPT.

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13459

13454

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>New Castle</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY IN 1b <u>UNKNOWN</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odesa</u>		d. STREET ADDRESS <u>46-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Clifford</u> Middle <u>Calloway</u> Last		4. DATE OF DEATH <u>Sept 21</u> Month <u>19</u> Day <u>66</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <u>61</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Distributor - Texaco Oil</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Roy H. Calloway</u>		14. MOTHER'S MAIDEN NAME <u>Mittie Watson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>22-22-4930</u>	
17. INFORMANT <u>Mr. and Mrs. Calloway, Odesa, Del.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, posterior</u> 4201 DUE TO <u>ASCVD with coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>UNKNOWN</u> (c) <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>F. J. Townsend, Jr.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F. J. Townsend, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>9/23/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Silver Brook Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Wilmington Del.</u>	
24. FUNERAL DIRECTOR <u>W. Lester Daniels, Middletown Del.</u>		ADDRESS	
25a. REC'D BY REGISTRAR <u>SEP 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10000

10000



# FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #1d Film #0381 9/26/66 pc

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13460

13455

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>md</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stockton</b>		c. LENGTH OF STAY IN lb <b>Pocomoke</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>P &amp; L Poultry Plant</b>		d. STREET ADDRESS <b>418 Bank ST</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Stewart Costen</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>15</b> Year <b>1966</b>	
5. SEX <b>m</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4 1927</b>
9. AGE (In years last birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>15</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>P&amp;L Poultry</b>	
11. BIRTHPLACE (State or foreign country) <b>md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Norvel Costen, sr.</b>		14. MOTHER'S MAIDEN NAME <b>Martha Ballard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WART II</b>		16. SOCIAL SECURITY NO. <b>215-20-4857</b>	
17. INFORMANT <b>Personal records &amp; state police</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>Pending 751X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) <b>Acute pulmonary Hemorrhage</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot left chest</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>9:40 a.m.</b> <b>9-15-66</b> P.M.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>P&amp;L Poultry</b>		20f. (City or town) (County) (State) <b>Stockton md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Thomas J. Roberts</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>THOMAS J. ROBERTS</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Ocean City 9-15-66</b> Address (Street, city, town, or county) <b>md</b>	
22. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-19-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Unionville</b>		23d. LOCATION (City or Town) (County) (State) <b>Pocomoke Worcester md</b>	
24. FUNERAL DIRECTOR <b>James H. Jones</b>		ADDRESS <b>New Church, Va.</b>	
25a. REC'D BY REGISTRAR DATE <b>SEP 20 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

T2-2008-914

Charles F. Johnson

22 5221 4 000

[illegible]

7.25 7.40 7.42

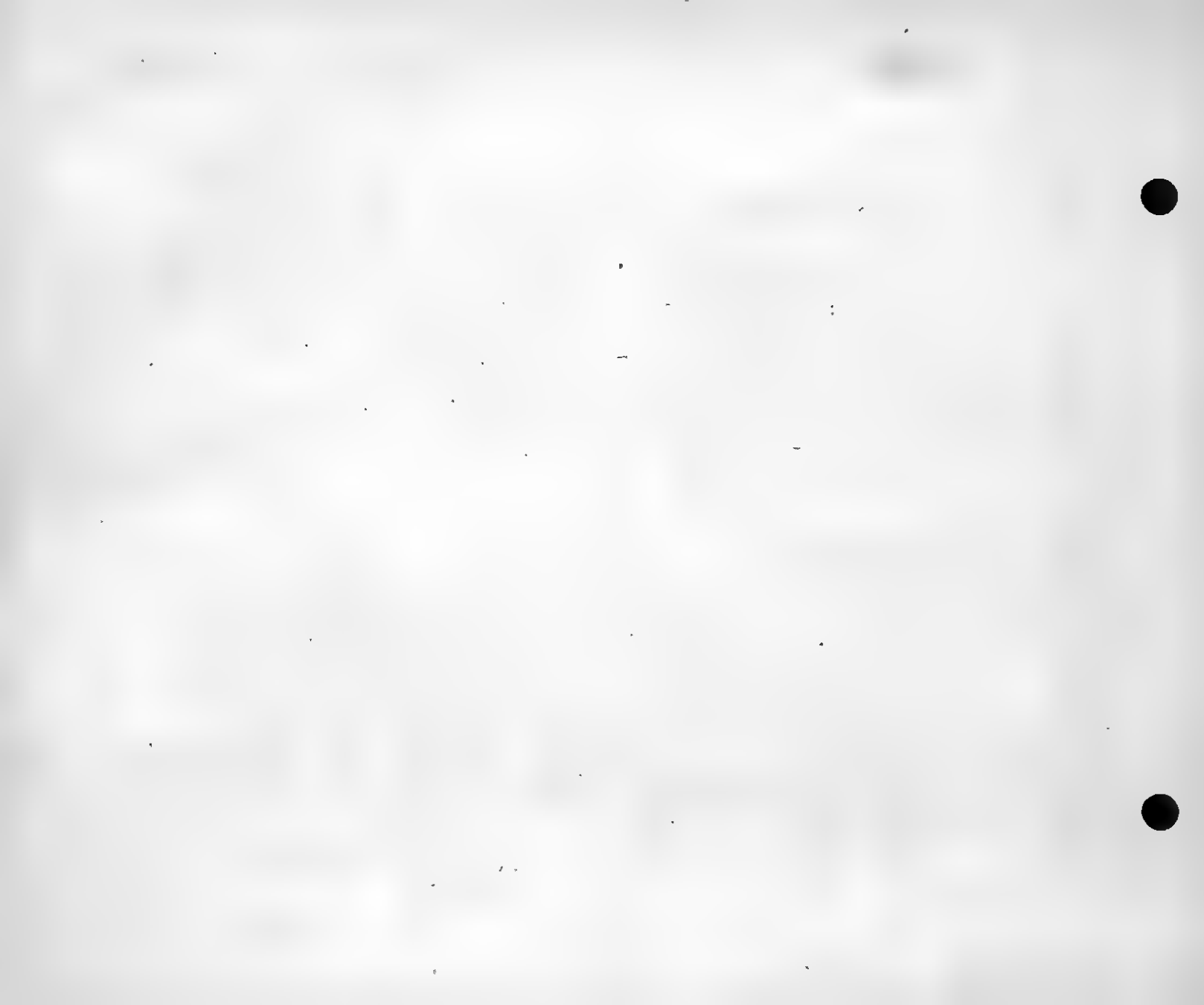
10000 9-11-12 x 10000 9-11-12

THOMAS J. MCGHEE  
275 E 12th St

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH					13456				
1. PLACE OF DEATH a. COUNTY Worcester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 917 Second Street					d. STREET ADDRESS 917 Second Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last NORA C. ELLIS					4. DATE OF DEATH Month Day Year September 16 1966				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1874		9. AGE (in years last birthday) 92 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Worcester County, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Niblett					14. MOTHER'S MAIDEN NAME Mahalia Blades				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Mildred Brimer, Pocomoke City, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Pulmonary Edema (b) Arteriosclerotic Heart Disease (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH 2 days Years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb. 16, 1966, to Sept. 16, 1966 that (I) last saw the deceased alive on Feb. 14, 1966, and that death occurred at 6 PM, from the causes and on the date stated above.									
22a. SIGNATURE Charles W. Trader					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 9-16-66	
22c. PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.					22d. ADDRESS 302 Market St. Pocomoke City, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-18-1966		23c. NAME OF CEMETERY Salem Methodist			23d. LOCATION (City, town or county) (State) Pocomoke City, Maryland		
24. FUNERAL DIRECTOR Robert H. Watson					ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR DATE SEP 20 1966		
					25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
 20M 5-63

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13457

1. PLACE OF DEATH a. COUNTY <u>Worcester</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS <u>Broad ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ARTHUR ENGLEHART GARRISON</u>		First Middle Last		4. DATE OF DEATH <u>SEPT. 28 1966</u>		Month Day Year	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 18, 1890</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POULTRY RAISER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALLSTON SPA, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES H. GARRISON</u>				14. MOTHER'S MAIDEN NAME <u>EVA ENGLEHART</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WORLD W. I</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs A. E. Garrison</u> Address <u>BERLIN MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>CHRONIC MYOCARDITIS</u> <u>44? X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSION - ARTERIOSCLEROSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>e.m.</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>9-28</u> , 19 <u>66</u> that (I) <u>(was)</u> saw the deceased alive on <u>9-28</u> , 19 <u>66</u> , and that death occurred at <u>9</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank Lewis</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>October 1, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frank Lewis</u>				22d. ADDRESS <u>Willsards Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/30/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City, town or county) (State) <u>BERLIN MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anne A. Burbage</u>				ADDRESS <u>Berlin Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 7 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13458

3458

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

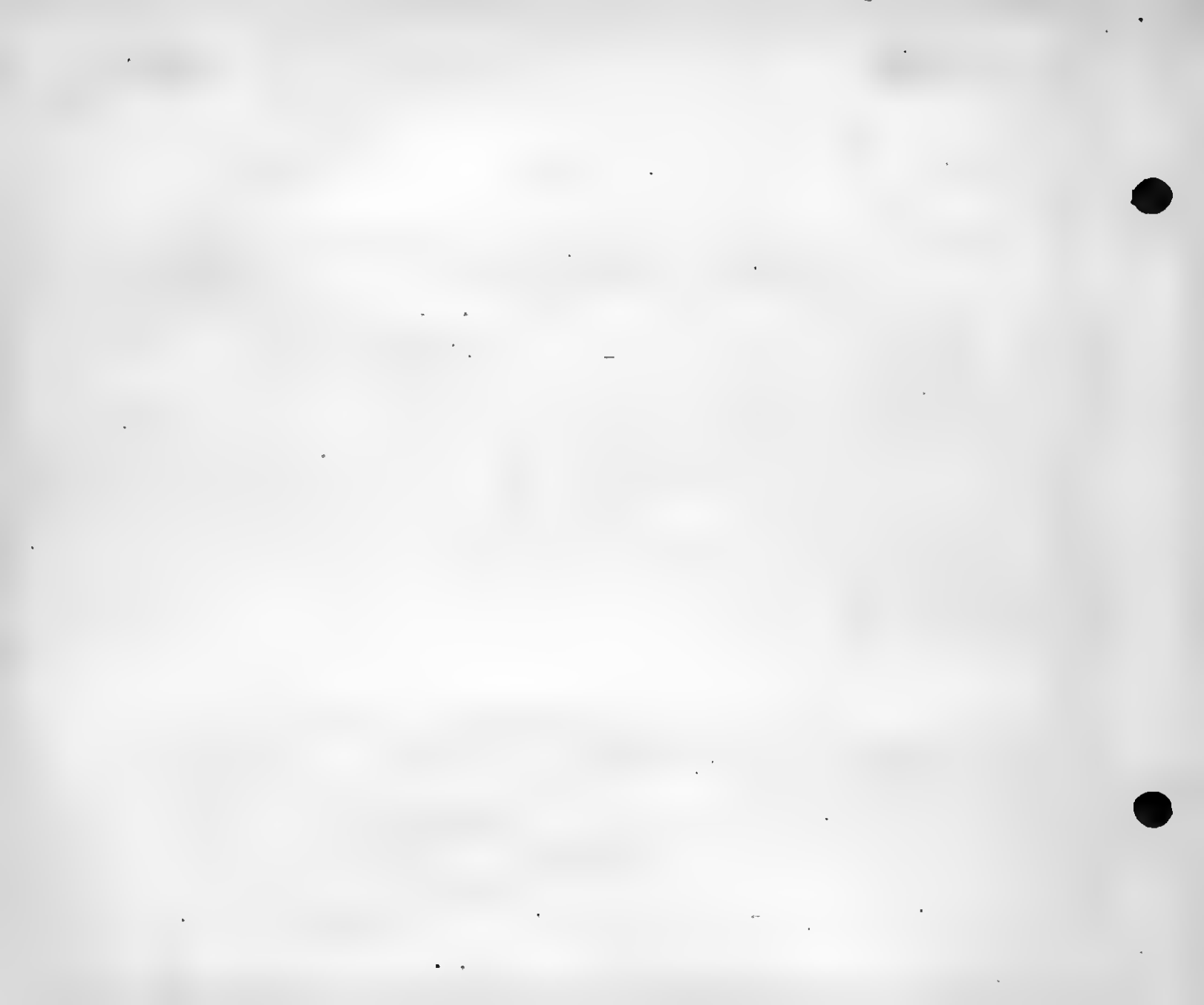
1 PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN IT	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <u>R.F.D.</u>	
3 NAME OF DECEASED (Type or print) First <u>ETHEL</u> Middle <u>M.</u> Last <u>HARMON</u>		4 DATE OF DEATH Month <u>SEPT</u> Day <u>23</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 23, 1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	9 AGE (In years last birthday) <u>63</u> yrs
11 BIRTHPLACE (County & State, or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>M. L. S. H. TAYLOR</u>		14. MOTHER'S MAIDEN NAME <u>MAGGIE HARMON</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17 INFORMANT <u>Mr. CURTIS TAYLOR</u>		Address <u>SELOXVILLE DEL</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 444X DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-20-66</u> to <u>9-23-66</u> , that (I) (we) last saw the deceased alive on <u>9-20-66</u> and that death occurred <u>9-23-66</u> M, from causes and on the date stated above			
22a SIGNATURE <u>Clifford E. Schott</u>		22b. DATE SIGNED	
22c. NAME (Type) <u>Clifford E. Schott MD</u>		22d. ADDRESS <u>Berlin Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>9/26/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	23d. LOCATION (City or Town) (County) (State) <u>BERLIN WOR. MD</u>
24. FUNERAL DIRECTOR <u>Anna C. Burby</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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34  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
13459

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Stockton		c. LENGTH OF STAY IN 1b 50 years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.F.D. 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last ANNIE ELIZABETH JONES		4. DATE OF DEATH Month Day Year September 8 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1880
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Accomack County, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William T. Justice		14. MOTHER'S MAIDEN NAME Sallie Dix	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFIRMANT Mrs Margaret J. Baylis, Maryland		Address Stockton,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>None</u> <u>Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> to <u>Sept</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>July 6</u> , 19 <u>66</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>David Rafat</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DAVID RAFAT		22d. ADDRESS Snow Hill, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-11-1966	
23c. NAME OF CEMETERY Brittingham Cemetery		23d. LOCATION (City, town or county) (State) Accomack County, Virginia	
24. FUNERAL DIRECTOR <u>Robert H. Watson</u>		25a. REC'D BY REGISTRAR DATE SEP 13 1966	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>Items 18&amp;19 Film 383 12-16 MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>13465 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13460</div>											
1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wor.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>				c. LENGTH OF STAY IN 1b <u>47 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>205 Wilcomico St</u>						d. STREET ADDRESS <u>205 Wilcomico St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Wesley Milbourne</u>						4. DATE OF DEATH Month <u>Sept.</u> Day <u>12</u> Year <u>1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 11, 1895</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>City Employee</u>		11. BIRTHPLACE (State or foreign country) <u>Chicago</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Julious Milbourne</u>						14. MOTHER'S M maiden name <u>MARY Fisher</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-28-121</u>		17. INFORMANT <u>Pauline Witcher, 205 Wilcomico St, Ocean City, Md</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Pulmonary edema acute</u> (b) <u>  </u> DUE TO <u>  </u> (c) <u>ASCVD with marked coronary sclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Approx. 5 year (estimated)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>[Signature]</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>F. S. Townsend, Jr.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Sept 12, 66</u>					
						Address (Street, city, county or country) <u>Ocean City, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-18-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>				23d. LOCATION (City or Town) (County) (State) <u>Berlin Worcester Md</u>			
24. FUNERAL DIRECTOR <u>Lowella B. Jolley</u>						ADDRESS <u>Jaray Rd. Salis, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 19 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

000001

000001



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13461

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hebron, Md.</b> c. LENGTH OF STAY IN 1b <b>2 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>none</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Id.</b> b. COUNTY <b>Caroline</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Federalsburg, Md.</b> d. STREET ADDRESS <b>rural</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Morgan A. Roberson</b>		4. DATE OF DEATH <b>Sept 10 1966</b>	
5. SEX <b>fem.</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3, 1886</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	9. AGE (in years last birthday) <b>79</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Vinton County Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Noah Dearth</b>		14. MOTHER'S MAIDEN NAME <b>Luninda Shelton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Roland Kaiser</b>		Address <b>Hebron, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Accidents</b> 331A DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arterio Sclerosis</b> (c) <b>3 yrs +</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Parkinsonism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 yrs +</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/12 1965</b> to <b>9/17 1966</b> , that (I) (we) last saw the deceased alive on <b>12/17 1966</b> , and that death occurred at <b>3:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>S.H. Curdler</b>		22b. DATE SIGNED <b>9/12/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>M.D.</b>		22d. ADDRESS <b>Hebron Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>Sept. 13, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Federalsburg, Md. RFD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey Wilkerson</b>		25a. REC'D BY REGISTRAR <b>SEP 14 1966</b>	
ADDRESS <b>Federalsburg, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

1900

RECEIVED

1900

TO THE HONORABLE SECRETARY OF THE INTERIOR

SIR:

I have the honor to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities.

I am, Sir, very respectfully, your obedient servant.

Very truly yours,

J. H. [Signature]

Assistant Secretary of the Interior

Washington, D. C.

Enclosed for you are two copies of the report of the

Commissioner of the General Land Office, dated the 10th inst.

and containing a full and complete statement of the

proceedings of the Board of Land Commissioners, in relation to

the application of the [Name] for a patent in fee simple

of the [Section] of the [Township] of the [County] of the [State]

and also a copy of the report of the [Name] of the [County] of the [State]

dated the 10th inst. and containing a full and complete statement of the

proceedings of the Board of Land Commissioners, in relation to the